580-1
Federal regulations provide, in pertinent part, that:

(b) A state plan must—

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility. (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

581-1
"Contract" means the written agreement entered into between a health care service plan (as defined in §1345, Health and Safety Code) and the Department and approved by appropriate state agencies to provide health care services to members under the provisions of the Waxman-Duffy Pre-paid Health Plan (PHP) Act, §14200, et seq., Welfare and Institutions Code. (§53108)

581-2
"Disenrollment" means the process by which a member's entitlement to receive services from a PHP is terminated. (§53114)

581-3
Except as provided in §53440, PHP membership shall continue indefinitely after enrollment. Membership shall be contingent upon the member's retention of Medi-Cal eligibility as well as eligibility for enrollment in the plan under the terms of the plan contract. (§53426)

581-4
Each prepaid health plan shall establish and maintain a procedure for submittal, processing and resolution of all member complaints. This section provides that such procedures shall be approved by the Department and shall provide for the processing of disenrollment requests through the grievance procedure. (§53260(a))

State law provides that the enrollment of a Medi-Cal beneficiary in a prepaid health plan shall not be terminated except for loss of eligibility, for good cause as determined by the Department, or at the request of the beneficiary. (Welfare and Institutions Code (W&IC) §14412(a))

583-1
State law permits the Director of the CDHS to designate any benefit or service included in the Medi-Cal Program, at state option under federal Medicaid rules, as a covered benefit only when provided by a Medi-Cal managed care plan to a Medi-Cal enrollee of the plan. (Welfare and Institutions Code (W&IC) §14131.15(a))

Where benefits and services have been designated by the Director under the above paragraph, beneficiaries who are eligible to enroll in and reside in the service area of a managed care plan, and who desire coverage for such benefits and services, must enroll in a Medi-Cal managed care plan to receive them. These beneficiaries shall, to the maximum extent permitted under federal law, remain enrolled in the plan. (W&IC §14131.15(b))

584-1
Enrollment in GMC is mandatory for eligible beneficiaries who meet all of the following criteria:

1. Are eligible for full scope Medi-Cal;

2. Have a zero SOC;

3. Do not qualify to select an alternative to GMC, under §53923.5;

4. Are eligible for AFDC, or linked to AFDC, to Foster Care, or to the MI program for children under age 21.

(§53906(a))

584-2
The CDHS or the GMC enrollment contractor shall mail an enrollment form and GMC plan information to each eligible beneficiary described in §53906(a). The mailing shall include GMC options presentation information and instructions to enroll in a GMC plan within thirty days of the postmark date on the mailing envelope. (§53921(c)) Each eligible beneficiary described in §53906(a) shall enroll in a GMC plan within thirty days of receipt of an enrollment form with instructions from the department or the GMC enrollment contractor to select a GMC plan. Under Subsection (1), in the event an eligible beneficiary described in §53906(a) does not enroll in a GMC plan within thirty days, the GMC enrollment contractor shall assign the eligible beneficiary to a GMC plan, in accordance with §53921.5. (§53921(d))

584-3
Each eligible beneficiary, prior to or upon either signing an enrollment application or being assigned to a GMC plan in accordance with §53921.5, shall be informed in writing by the department or the GMC enrollment contractor of at least the following:

(1) There will be a 15 to 45 day processing time between the date of application and the effective date of enrollment in a GMC plan.

(2) Until GMC plan enrollment is effective, the beneficiary may receive Medi-Cal covered health care services from any Medi-Cal provider licensed to provide the services.

(3) An alternative to GMC plan enrollment exists.

(4) Disenrollment from certain GMC plans, specified in §53925.5, is restricted during the second through sixth month of enrollment.

(§53926.5(a))

584-4
Each GMC plan shall provide in writing, in addition to those items of information required by W&IC §14406, the following to each member within seven days after the effective date of enrollment in the plan:

(1) The effective date of enrollment.

(2) A description of all available services and an explanation of any applicable service limitations, exclusions from coverage or charges for services.

(3) The name, telephone number and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days or be assigned to one.

(4) An enrollment/disenrollment form and an explanation that it must be used to disenroll from the GMC plan, in the event disenrollment is requested by the member.

(5) Information concerning non-medical transportation available to the beneficiary under the Medi-Cal program, or offered by the GMC plan, if applicable, and how to receive it.

(§53926.5(b))

584-5
Each eligible beneficiary enrolling in a GMC plan shall enroll in one dental plan and either one PHP or one PCCM plan. (§53921(e))

584-6
The GMC enrollment contractor shall assign an eligible beneficiary described in §53906(a) to a GMC plan, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a PHP or PCCM plan and a dental plan within thirty days of receiving an enrollment form pursuant to §53921(c).

(2) In the event a member requests and is granted disenrollment from a GMC plan (pursuant to §53925.5) but does not select a different GMC plan (pursuant to §53925.5) in which to enroll: Unless that member was granted approval by the GMC enrollment contractor to receive health care services through the fee-for-service Medi-Cal program (pursuant to §53923.5).

(§53921.5(a))

584-7
No member who is assigned to a GMC plan under §53921.5 shall be denied a request for disenrollment if all primary health care services through that assigned GMC plan are more than 10 miles from the beneficiary's residence. (§53922.5(a))

584-8
An eligible beneficiary specified in §53906(a) who meets the requirements of (a) or (b) may request from the GMC enrollment contractor an alternative to GMC plan enrollment.

(a) An eligible beneficiary who is an Indian, is a member of an Indian household, or has written acceptance from an Indian Health Service program facility to receive health care services through that facility, may, as an alternative to GMC plan enrollment and upon request, choose to receive health care services through an Indian Health Service

program facility.

(b) An eligible beneficiary who is receiving treatment or services for a complex medical situation from a physician who is participating in the Medi-Cal program, but is not a contracted provider of any GMC plan, may request continued fee-for-service Medi-Cal for the purposes of continuity of care. The department may approve continued treatment under the fee-for-service Medi-Cal program for any eligible beneficiary whose diagnosis or treatment needs are verified in writing by the beneficiary's Medi-Cal provider and who meets one of the criteria below in 1 though 3 for continued fee-for-service Medi-Cal.

(1) The eligible beneficiary is under the care of a physician specialist:

(A) For treatment of a condition that is within the specialist's scope of practice, pursuant to the Business and Professions Code;

(B) That specialty is not practiced by any physician within the available providers of any GMC plan; and

(C) That specialist is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(2) The eligible beneficiary is in a complex, high risk medical treatment plan:

(A) Under the supervision of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan; and

(B) May experience deleterious medical effects if that treatment were to be disrupted by leaving the care of that physician to begin receiving care from a GMC plan physician.

(3) The eligible beneficiary is a woman who is pregnant and under the care of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(c) Any eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(1) or (2) may remain with that fee-for-service physician only until the medical condition has stabilized to a level that would enable the eligible beneficiary to change physicians and begin receiving care from a GMC plan physician without deleterious medical effects. An eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(3) may remain with that physician through delivery and the end of the month in which ninety days post-partum occurs.

(§53923.5)

584-9
State regulations require that:

(a) Each GMC plan shall have a mechanism in place and approved in writing by the department to ensure that each member is assigned to a primary care provider, by either:

(1) Allowing each member to select a primary care provider from the GMC plan's network of affiliated providers, if the member chooses to do so; or

(2) Assigning a primary care provider to each member within forty days from the effective date of enrollment, if the member does not select one within the first thirty days of the effective date of enrollment in the GMC plan.

(A) Assignment conducted pursuant to (a)(2) shall meet both 1 and 2:

1. The member shall be assigned to a primary care provider no more than 10 miles from the beneficiary's residence.

2. If available within the GMC plan, the member shall be assigned to a primary care provider who is or has office staff who are linguistically and culturally competent to communicate with the member or have the ability to interpret in the provision of health care services and related activities during the member's office visits or contacts, if the language or cultural needs of the member are known to the GMC plan.

(b) Any member dissatisfied with the primary care provider selected or assigned shall be allowed to select or be assigned to another primary care provider. Each GMC plan shall assist its members in changing primary care providers if that change is requested by the member. Any GMC plan physician or dentist dissatisfied with the professional relationship with any member may request that the member select or be assigned to another primary care provider.

(§53925)